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ABSTRACT

This digest focuses on the clinical supervision of counselors involved in addictions counseling. An overview notes the growing field of addictions counseling and describes Powell's model of clinical supervision which blends aspects of several supervision theories. This model is developmental in nature, addresses nine descriptive dimensions of clinical supervision issues. These include: influence, therapeutic strategy, and counsel or in-house treatment. Issues specific to addictions counseling and supervision are outlined. The next section considers what it is that makes addictions supervision different from other forms of supervision. Three supervision issues that are idiosyncratic to substance abuse counseling are identified: the fact that a significant number of addictions treatment providers are paraprofessionals; the belief of many professional counselors and paraprofessionals facilitating addictions treatment that one must be in recovery to provide effective treatment; and that, to some degree, all treatment providers are influenced by personal issues. Other ingredients vital to the supervision process are discussed. Contains 5 references. (NB)

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ERIC CLEARINGHOUSE ON Counseling And Student Services

ERIC DIGEST

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Clinical Supervision in Addictions Counseling: Special Challenges and Solutions

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Overview

Since the early 1970's addictions counseling has experienced significant growth and change. Addictions treatment has become "big business" and as a result, there is a new consciousness for cost management and containment. Top priorities now include reducing staff turnover, preventing employee burnout, and maintaining credentialing to meet insurance reimbursement requirements (Powell, 1993). As the field matures, continued professional training becomes increasingly important. Declining budgets within many agencies, however, often prohibit participation in costly seminars designed to promote advanced clinical skills. A solution to this dilemma is ongoing, in-house clinical supervision (Powell, 1991).

In the addictions profession's infancy, supervision was often little more than a more senior level helper telling another what to do. In addition, directions to the junior level treatment provider were primarily based upon the supervisor's personal recovery experience. Today, a more professional and systematic approach to clinical supervision is warranted. A good counselor won't necessarily be a good supervisor (Machell, 1987). Therefore, addictions supervisors need to be well versed in both advanced supervision techniques and addictions counseling.

Despite increased numbers of addictions treatment programs over the past twenty years, addictions supervision has been virtually neglected. Evidence of this is demonstrated through the limited number of journal articles written on the topic of addictions supervision. For example, a recent search for articles written on the topic resulted in only ten citations; of these, only four specifically addressed the topic of providing clinical addictions supervision.

One conspicuous exception has been the work of David Powell, who has written consistently about addictions supervision since the mid 1970s. His seminal writings have resulted in descriptive and data-based articles, culminating in the recent publication of his second book on supervision in addictions counseling. Powell (1993) has developed a model of clinical supervision which blends aspects of several supervision theories. His model is developmental in nature and addresses nine descriptive dimensions of clinical supervision issues (e.g., influence, therapeutic strategy, counselor in treatment, etc.). Powell also outlines issues specific to addictions counseling and supervision. It is because of these unique aspects of addictions counseling that attention is greatly needed in the area of supervision.

What Makes Addictions Supervision Different?

Although a great number of issues related to the supervision process are similar across different types of counseling (e.g., school, mental health, family, career, etc.), at least three supervision issues are idiosyncratic to substance abuse counseling and deserve special attention (Powell, 1993). First, a significant number of addictions treatment providers are paraprofessionals. Unlike professional counselors, paraprofessionals have not fulfilled the educational requirements for a master's degree in counseling or an allied human service field. Paraprofessionals in some states are required to have little more than a high school diploma or equivalent and pass a state certification examination. They, therefore, lack formal graduate school instruction pertinent to the eight common core areas considered rudimentary to the counseling profession (i.e., human growth and development, social and cultural foundations, helping relationships, group, lifestyle and career development, appraisal, research and evaluation, and professional orientation). Paraprofessionals also may lack the fundamental counseling skills typically developed through participation in an organized sequence of practica and field-practica experiences (e.g., counseling internships) common to counselor education program graduates. The implication for supervision is clear. Supervisors must be continually aware that paraprofessionals lack fundamental counselor training. Therefore, the supervision milieu must contain a strong educational component to ensure a minimal level of skill and knowledge-based competencies. Supervisors may find that informal lectures related to counseling theories and practice of counseling techniques enhance clinical sophistication and promote greater treatment effectiveness. Undoubtedly, clinical supervisors working with paraprofessionals who lack adequate training may need to assume a greater proportion of the responsibility for treatment planning and can help paraprofessionals learn how to apply their existing skills with diverse clients.

A second complicating factor related to addictions supervision is that many professional counselors and paraprofessionals facilitating addictions treatment strongly believe that one must bein recovery to provide effective treatment (Powell, 1993). Treatment providers espousing such a "recovery-only" position may be highly resistant to supervision from non-recovering persons. Direct inquiry by the supervisor can be helpful in understanding the counselor's position on this matter. For example, the supervisor may find it helpful to ask the supervisee, "How will my not being in recovery effect our supervision relationship?" Whatever the response

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indicated by the supervisee, the supervisor will need to follow-up by asking, "How can we effectively work together so our clients receive the best possible treatment?" Such directness is typically prized within the substance abuse community and encourages supervisee honesty. Failure to address this important topic can result in pseudo-supervision, which wastes valuable time and inevitably impedes client progress. Even the most adamant helper who believes one needs to be in recovery to facilitate effective addictions treatment, will typically recognize the benefits of supervision when the emphasis is placed upon working together for the sake of the client.

Finally, it should be noted that to some degree all treatment providers' are influenced by personal issues. In an attempt to be helpful, however, recovering helpers may be particularly vulnerable to imposing their personal experiences and unconscious beliefs on a client (e.g., what worked for me will work for you). A client's relapse also may provoke unconscious responses in the recoveringhelper (i.e., loss of empathy, reduction in patience, etc.) which may negatively effect the counseling relationship. Therefore, the supervisor's attentiveness to these possible issues is critical. Encouraging recovering helpers to embark on a "recovery expedition" can be helpful. Here, helpers ask others how they initiated their recovery experience and what things they find helpful to maintain chemical abstinence. Participation in the recovery expedition teaches helpers that there exists no single method in which people initiate or maintain the recovery process. Helper behaviors, cognitions and feelings resulting from a client's relapse or a client's unwillingness to commit to the abstinence process can be discussed within small group experiences. Such small group experiences can promote effective ways of dealing with anger, frustration, and fear related to the helper's own recovery.

Other Ingredients Vital to the Supervision Process

Because supervision has been neglected within many addictions agencies, basic supervision practices are often foreign to addictions helpers. Therefore, it is critically important for addictions supervisors, as it is for all supervisors, to establish supervision practices in a nondemeaning manner which emphasizes client benefits. To secure such practices, it is imperative that addictions supervisors: 1) establish a solid working relationship with the supervisee, 2) assess the supervisee's counseling skills, 3) agree to contract for the conduct of supervisory sessions, and 4) establish learning goals with the supervisee (Borders & Leddick, 1987). Mutually agreed upon goals for supervision need to be concrete, attainable, and specific. Together, both the supervisor and the supervisee need to determine methods for attaining these goals and ways to evaluate progress in each area (Bradley & Boyd, 1989).

Effective supervision principles include consistent meeting times and a collegial atmosphere, both of which contribute to a working relationship vis-a-vis a structured hierarchy in which thesupervisor dictates counseling interventions. This promotes the supervisee's "ownership" of the case. As both supervisor and supervisee become more familiar with the working relationship, professionalism grows and clients benefit. This typically lends to increased supervisee effectiveness and satisfaction.

Conclusion

A number of factors endemic to the addictions field make supervision within this community both challenging and rewarding. Effective supervision requires developing the skills of front-line staff at all levels and addressing possible supervisee concerns related to non-recovering treatment providers. When these issues are adequately addressed within the supervision process, the promotion of professionalism and professional identity will occur.

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